

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08361

08358

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lusby,</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lusby.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Maple</u> (Middle) (Last) <u>Brown</u>				(Month) <u>8</u> , (Day) <u>31</u> , (Year) <u>19 57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Feb 18</u>	9. AGE last birthday <u>41</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Kelso Buck</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Howard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Jenne Buck Lusby, ind.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
171X IMMEDIATE CAUSE (A) <u>Ca of Cervix</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 1, 1957, to Aug 31, 1957, that I last saw the deceased alive on Aug 31, 1957, and that death occurred at 7:30 P.M. from the causes and on the date stated above.							
SIGNATURE <u>R. W. Ward</u> M.D.		DATE SIGNED <u>9/3/57</u>		ADDRESS (Street, city, town, state)			
23. (BURIAL) CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>9-3-57</u>		NAME OF CEMETERY OR CREMATORY <u>Eastern Chapel</u>		LOCATION (City, town, or county) (State) <u>Calvert Co. md</u>	
24. REC'D BY REGISTRAR DATE <u>9-3-57</u>		REGISTRAR'S SIGNATURE <u>H. W. Ward</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P. Z. Sewell. Prince Fred. ind</u>			

CERTIFICATE OF DEATH

REG. ONE, 1957

1. DECEASED'S NAME (LAST, FIRST, MIDDLE)

2. PLACE OF DEATH

3. SEX

4. AGE

5. DATE OF DEATH

6. TIME OF DEATH

7. PLACE OF BIRTH

8. OCCUPATION

9. CAUSE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF CLERK

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF CORONER

18. SIGNATURE OF DISTRICT ATTORNEY

19. SIGNATURE OF COUNTY CLERK

20. SIGNATURE OF TOWNSHIP CLERK

21. SIGNATURE OF VOTER

22. SIGNATURE OF JURY

23. SIGNATURE OF JUDGE

24. SIGNATURE OF SHERIFF

25. SIGNATURE OF CORONER

26. SIGNATURE OF DISTRICT ATTORNEY

27. SIGNATURE OF COUNTY CLERK

28. SIGNATURE OF TOWNSHIP CLERK

29. SIGNATURE OF VOTER

30. SIGNATURE OF JURY

31. SIGNATURE OF JUDGE

32. SIGNATURE OF SHERIFF

33. SIGNATURE OF CORONER

34. SIGNATURE OF DISTRICT ATTORNEY

35. SIGNATURE OF COUNTY CLERK

36. SIGNATURE OF TOWNSHIP CLERK

37. SIGNATURE OF VOTER

38. SIGNATURE OF JURY

39. SIGNATURE OF JUDGE

40. SIGNATURE OF SHERIFF

41. SIGNATURE OF CORONER

42. SIGNATURE OF DISTRICT ATTORNEY

43. SIGNATURE OF COUNTY CLERK

44. SIGNATURE OF TOWNSHIP CLERK

45. SIGNATURE OF VOTER

46. SIGNATURE OF JURY

47. SIGNATURE OF JUDGE

48. SIGNATURE OF SHERIFF

49. SIGNATURE OF CORONER

50. SIGNATURE OF DISTRICT ATTORNEY

51. SIGNATURE OF COUNTY CLERK

52. SIGNATURE OF TOWNSHIP CLERK

53. SIGNATURE OF VOTER

54. SIGNATURE OF JURY

55. SIGNATURE OF JUDGE

56. SIGNATURE OF SHERIFF

57. SIGNATURE OF CORONER

58. SIGNATURE OF DISTRICT ATTORNEY

59. SIGNATURE OF COUNTY CLERK

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79. SIGNATURE OF JUDGE

80. SIGNATURE OF SHERIFF

81. SIGNATURE OF CORONER

82. SIGNATURE OF DISTRICT ATTORNEY

83. SIGNATURE OF COUNTY CLERK

84. SIGNATURE OF TOWNSHIP CLERK

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89. SIGNATURE OF CORONER

90. SIGNATURE OF DISTRICT ATTORNEY

91. SIGNATURE OF COUNTY CLERK

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99. SIGNATURE OF COUNTY CLERK

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101. SIGNATURE OF VOTER

102. SIGNATURE OF JURY

103. SIGNATURE OF JUDGE

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106. SIGNATURE OF DISTRICT ATTORNEY

107. SIGNATURE OF COUNTY CLERK

108. SIGNATURE OF TOWNSHIP CLERK

109. SIGNATURE OF VOTER

110. SIGNATURE OF JURY

111. SIGNATURE OF JUDGE

112. SIGNATURE OF SHERIFF

113. SIGNATURE OF CORONER

114. SIGNATURE OF DISTRICT ATTORNEY

115. SIGNATURE OF COUNTY CLERK

116. SIGNATURE OF TOWNSHIP CLERK

117. SIGNATURE OF VOTER

118. SIGNATURE OF JURY

119. SIGNATURE OF JUDGE

120. SIGNATURE OF SHERIFF

121. SIGNATURE OF CORONER

122. SIGNATURE OF DISTRICT ATTORNEY

123. SIGNATURE OF COUNTY CLERK

124. SIGNATURE OF TOWNSHIP CLERK

125. SIGNATURE OF VOTER

126. SIGNATURE OF JURY

127. SIGNATURE OF JUDGE

128. SIGNATURE OF SHERIFF

129. SIGNATURE OF CORONER

130. SIGNATURE OF DISTRICT ATTORNEY

131. SIGNATURE OF COUNTY CLERK

132. SIGNATURE OF TOWNSHIP CLERK

133. SIGNATURE OF VOTER

134. SIGNATURE OF JURY

135. SIGNATURE OF JUDGE

136. SIGNATURE OF SHERIFF

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141. SIGNATURE OF VOTER

142. SIGNATURE OF JURY

143. SIGNATURE OF JUDGE

144. SIGNATURE OF SHERIFF

145. SIGNATURE OF CORONER

146. SIGNATURE OF DISTRICT ATTORNEY

147. SIGNATURE OF COUNTY CLERK

148. SIGNATURE OF TOWNSHIP CLERK

149. SIGNATURE OF VOTER

150. SIGNATURE OF JURY

151. SIGNATURE OF JUDGE

152. SIGNATURE OF SHERIFF

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252. SIGNATURE OF TOWNSHIP CLERK

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254. SIGNATURE OF JURY

255. SIGNATURE OF JUDGE

256. SIGNATURE OF SHERIFF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08359

CERTIFICATE OF DEATH

08362

Reg. Dist. No.

51

1. PLACE OF DEATH o. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Life</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Isaac</u> Middle <u>Edward</u> Last <u>Cox</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 28, 1871</u>	
9. AGE (In years, last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Calvert Co. Md.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James Cox</u>			
14. MOTHER'S MAIDEN NAME <u>Margaret Tucker</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>No</u>				17. INFORMANT <u>Stanley Cox</u> Address <u>Huntingtown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GASTRIC HEMORRHAGE</u> <u>151X</u> DUE TO (b) <u>Probably Carcinoma of Stomach</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROSIS</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Page Jett</u> M.D. <u>Perce Fedeuch</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>PAGE C. JETT M.D.</u>				<u>Perce Fedeuch Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug 3, 1957</u>		<u>Emmanuel Cemetery</u>		<u>Plum Point Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Harkness & Son</u> ADDRESS <u>Mutual, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>8-2-57</u>		24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	

BUREAU V. S.

1957 2 57.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09311

Reg. Dist. No.

51

08360

1. PLACE OF DEATH a. COUNTY <u>Cabot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Beach</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Shice</u> First <u>E</u> Middle <u>W</u> Last <u>W</u>		4. DATE OF DEATH Month <u>8</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26, 1910</u>
9. AGE (In years last birthday) <u>47</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash DC</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash DC</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>J B Sheehy</u>		14. MOTHER'S MAIDEN NAME <u>Jeann Eickhoff</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war dates of service)	
17. INFORMANT <u>June Costello</u> Address <u>58250-1st St, NW</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Crown disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>	
Conditions, if any, which gave rise to immediate cause (b)		DUE TO (c)	
(a), stating the underlying cause lost.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had several attacks</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>8/24</u> <u>1957</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>W Beach Cabot</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H W Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8/24/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-28-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wash Natl Cem -</u>		22d. LOCATION (City, town, or county) <u>Switzland Rd - Pr. Geo. Co. Md.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas M. Idyong</u> ADDRESS <u>137th N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>OK</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Ward</u>		DATE <u>8/24/57</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

SEP 23 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08361

CERTIFICATE OF DEATH

Reg. Dist. No.

08363

51

1. PLACE OF DEATH a. COUNTY <u>Cabot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Cabot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelina</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Adelina</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Jennie</u> Middle <u>W.</u> Last <u>Duke</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 14, 1868</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months <u>3</u> Days <u>28</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gardner Wadleigh</u>		14. MOTHER'S MAIDEN NAME <u>Jane Carhile</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Conita Kerney</u>		Address <u>Adelina, Ind</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO (b) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>44 years 4 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1953</u> , to <u>Aug 12</u> , 1957, that I last saw the deceased alive on <u>Aug 12</u> , 1957, and that death occurred at <u>7:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Page Jett</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>PRINCE FREDERICK 8/13/57</u>	
PHYSICIAN'S NAME (Type) <u>PAGE C. JETT</u>		M.D. <u>Prince Frederick Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Aug. 15, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G.A. Watkins & Son Funeral, Ind.</u>		24a. REC'D BY REGISTRAR <u>8-13-57</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>H.W. Ward</u>	

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08362

Item 8 Film 0220 9-13-57 et

CERTIFICATE OF DEATH

08364

Reg. Dist. No. 51

1. PLACE OF DEATH o. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Pittsburg			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 75 X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert Co., Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Albert Last Feldman				4. DATE OF DEATH Month August Day 9 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-19-1904	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Steel Company Pa.		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Morris E. Feldman				14. MOTHER'S MAIDEN NAME Garnet Goldman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ? (If yes, give year or dates of service) ?		16. SOCIAL SECURITY NO. ?		17. INFORMANT Phyllis Feldman Wife Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 17 days						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/6 , 19 57 , to 8/9 , 19 57 , that I last saw the deceased alive on 8/8 , 19 57 , and that death occurred at 10:30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE G. J. Weems		M.D. Huntingtown, Md		ADDRESS (Street, city or town, state)		DATE SIGNED 8/9/57	
PHYSICIAN'S NAME (Type) Dr. George Weems							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Aug. 9, 1957		22c. NAME OF CEMETERY OR CREMATORY Slater Funeral Home		22d. LOCATION (City, town, or county) (State) Pittsburgh, Pa	
23. FUNERAL DIRECTOR'S SIGNATURE A. A. Harkness & Son - Mutual Ind				24a. REC'D BY REGISTRAR 8/9/57		24b. REGISTRAR'S SIGNATURE H. W. Ward	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08365/51

Reg. Dist. No.

08363

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calvert</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calvert</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Life</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Harrison</u> Middle <u>Lerner</u> Last				4. DATE OF DEATH Month <u>Aug</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>9-8</u>		9. AGE (In years last birthday) <u>67</u> yrs		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		13. FATHER'S NAME <u>James Garner</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Rich</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>217-05-3848</u>		17. INFORMANT <u>Sda M. Garner, husb., md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
20f. (City or town) <u>Princess Anne</u>		(County) <u>St. Mary's</u>		(State) <u>MD</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4 Aug 57</u>			
EXAMINER'S NAME (Type) <u>P. E. Sewell</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>8-6-57</u>					
22b. DATE THEREOF <u>8-6-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		22d. LOCATION (City, town, or county) <u>Princess Anne</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u>		ADDRESS <u>Prince Frederick</u>		24a. REC'D BY REGISTRAR <u>8-5-57</u>			
24b. REGISTRAR'S SIGNATURE <u>N. W. Ward</u>		DATE					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for to burial, cremation, or removal.

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08364

CERTIFICATE OF DEATH

Reg. Dist. No.

08366

1. PLACE OF DEATH a. COUNTY <u>Cabnet</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cabnet</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelina</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelina</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>—</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>LENORA</u> Middle <u>B.</u> Last <u>MORSELL</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 25, 1898</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR: Months <u>5</u> Days <u>15</u> Hours <u>—</u> Min. <u>—</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Cabnet Co., Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cephas H. Bowen</u>				14. MOTHER'S MAIDEN NAME <u>Sally Skinner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-34-42</u>		17. INFORMANT <u>John B. Morcell - Adelina, Ind.</u> Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> <u>464X</u> DUE TO (b) <u>Popliteal Phlebitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>7 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 12, 1957</u> to <u>Aug 10, 1957</u> , that I last saw the deceased alive on <u>August 10, 1957</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Page C. Jett</u> M.D. <u>Prince Frederick</u>				ADDRESS (Street, city or town, state) <u>—</u> DATE SIGNED <u>—</u>			
PHYSICIAN'S NAME (Type) <u>PAGE C. JETT</u>				<u>PRINCE FREDERICK</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 13, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Frederick, Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Hackbusch & Son - Mutual, Ind.</u> ADDRESS <u>—</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>8-12-57</u>		24b. REGISTRAR'S SIGNATURE <u>N. W. Ward</u>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08365

CERTIFICATE OF DEATH

08367

Reg. Dist. No. 51

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Huntingtown</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Huntingtown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Wesley S. Parran</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>8</u> <u>1</u> 19 <u>57</u>			
5. SEX <u>m</u>	6. COLOR OR RACE <u>S</u>	7. SINGLE/MARRIED/WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Feb 12</u>		9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James T. Parran</u>				14. MOTHER'S MAIDEN NAME <u>Christiana Ray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>91-12-5391A</u>		17. INFORMANT & ADDRESS <u>Mildred Parran, Huntingtown, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
151X IMMEDIATE CAUSE (A) <u>Carcinoma of stomach</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B)							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5-1, 1957, to 8/1, 1957, that I last saw the deceased alive on 8/1, 1957, and that death occurred at 9:30 P.M. from the causes and on the date stated above.							
SIGNATURE <u>P. E. Sewell</u>		DATE THEREOF <u>8-4-57</u>		NAME OF CEMETERY OR CREMATORY <u>St Edmunds</u>		LOCATION (City, town, or county) (State) <u>Calvert Md</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR DATE <u>8-4-57</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell, Jr., Frederick, Md</u>		DATE SIGNED <u>8/3/57</u>	

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6 AUG 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 08366
 Item 2 Film G220 9-11-57 at
 CERTIFICATE OF DEATH

08368

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick c. LENGTH OF STAY IN 1b 39 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) "Rosehaven" North Beach d. STREET ADDRESS 02x2-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Susan A. Saunders				4. DATE OF DEATH Month Day Year 8 31 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/4/77	
9. AGE (In years last birthday) 80 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Homemaker, retired)		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME Joseph Harding			
14. MOTHER'S MAIDEN NAME Amelia Graves				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT Joseph Saunders, N. Beaulieu			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio Vascular renal disease 903.0 DUE TO Cere Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fractured Hip (c) 6 wks						INTERVAL BETWEEN ONSET AND DEATH 6 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fall and fracture by and under shoulder						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was walking across floor and fell			
20c. TIME OF INJURY Hour o. m. p. m. 1130 July 23 1957				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) N. Beaulieu				20g. (County) AA		20h. (State) MD	
21. I certify that I attended the deceased from 7/23 , 19 57 , to 8/31 , 19 57 , that I last saw the deceased alive on 8/21 , 19 57 , and that death occurred at 12:50 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE H W Ward				DATE SIGNED Owings, Maryland			
PHYSICIAN'S NAME (Type) Dr. Hugh W. Ward							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/3/57		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS Silver Spring, Maryland		24a. REC'D BY REGISTRAR SEP 3 1957	
				24b. REGISTRAR'S SIGNATURE Hugh W. Ward			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

NAME OF DECEASED John Doe		DATE OF BIRTH Jan 1, 1900	
SEX Male		RACE White	
MARRIAGE Married		EDUCATION High School	
OCCUPATION Teacher		RESIDENCE 123 Main St, Baltimore, Md.	
DATE OF DEATH Dec 15, 1957		PLACE OF DEATH Home	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN <i>[Signature]</i>		SIGNATURE OF REGISTRAR <i>[Signature]</i>	
DATE OF SIGNATURE Dec 16, 1957		DATE OF SIGNATURE Dec 16, 1957	

BUREAU V. S.

SEP 3 1957

RECEIVED